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Applicability For Persons Receiving Services in:	Intermediate Care Facilities for Persons with Mental Retardation, Community Day and Residential Programs and Non-Residential Programs
Applicability:	All DDSN and Contracted Providers of Service Coordination, Early Intervention, Residential and Day Services

PURPOSE

To establish the guidelines for building effective positive behavioral supports for people who have challenging behaviors and receive supports from DDSN or its contracted providers. This policy additionally specifies needed approvals for use of behavioral support procedures and identifies those that are prohibited.

PHILOSOPHY

POSITIVE BEHAVIORAL SUPPORT

Positive behavioral support recognizes that people exhibit problem behavior because it serves a useful purpose for them in their current situation. The focus of positive behavioral supports begins with understanding the function of the problem behavior. Once it is known why the problem occurs for an individual, procedures can be developed to teach and promote alternatives that can replace the problem behavior. The goal is not just to eliminate the undesirable behavior. The focus should be to create environments and patterns of support for the person that makes the problem behavior irrelevant, ineffective, or inefficient. The key outcome of positive behavioral supports should be an improvement in quality of life for the person that includes the replacement

of problem behavior(s) with appropriate alternatives that serve the same purpose. It is the philosophy of DDSN that people will be free from any serious risk to physical and psychological health and safety at all times, including during the development of a Behavior Support Plan. Procedures used to insure safety should not be misunderstood to substitute for procedures to provide positive behavioral supports.

DDSN believes that those who develop behavioral support plans be knowledgeable in the values, theory, and practices of positive behavioral support as provided in the "Functional Assessment and Program Development for Problem Behavior: A Practical Handbook" by O'Neill, Horner et. Al. (Brookes/Cole Publishing Company, 1997) or other similar guides to effective, evidence-based practices in positive behavioral support.

I. STATEMENT OF POLICY

A physical and social environment that is safe, humane, and responsive to a person's needs is a necessary building block for effective supports. Problems or shortcomings in the basic environment must be addressed since effective behavioral support is not likely to occur without an environment that is functional for the person. In order to develop the most effective BSP, the following resources and supports should be available:

A. Environments that make sense for the individual (i.e. providing meaningful support)
*** See Attachment I for more detailed information on each item**

- Meaningful and Individualized Training Opportunities
- Social Interactions
- Activities/Tasks/Work That Are Functional
- Community Inclusion
- Supervision and Accountability of Staff

B. Additional Supports As Needed:
*** See Attachment I for more detailed information on each item**

- Environmental Accommodations
- Medical Diagnosis and Treatment
- Psychiatric Services
- Functional Communication Evaluation and Intervention
- Neuro-Psychological Evaluation
- Psychological Counseling
- Specialized Placements
- Enhanced Staffing

II. DEVELOPING POSITIVE BEHAVIOR SUPPORT PLANS

A. Functional Assessment

Functional assessment is a process for gathering information that can be used to maximize the effectiveness and efficiency of behavioral supports (O'Neill, et. al, 1997, p. 3). It is complete when the following five outcomes have been achieved:

1. The problem behaviors, including classes or sequences of behaviors that frequently occur together are described clearly.

2. The events, times, and situations that predict when the problem behaviors will and will not occur across the full range of typical daily routines are identified.

3. The consequences that maintain the problem behaviors (that is what function{s} the behaviors appear to serve for the person) are identified.

4. One or more summary statements or hypotheses that describe specific behaviors, a specific type of situation in which they occur, and the outcomes or reinforcers maintaining them in that situation are developed.

5. Direct observation data that support the summary statements that have been developed are collected.

Precautionary measures to protect the person and others from harm shall always be taken during the course of functional assessment of problem behavior. A functional assessment will include, but not be limited to the following elements, in conjunction with and to help achieve the five outcomes previously mentioned:

1. An operational definition of the problem behavior(s)in objective and measurable terms.

2. Consideration of the risks of the problem behavior(s) to the person, others, and the environment.

3. Structured interviews with the person, if applicable, staff, family, and/or relevant others who work directly with the person.

4. Consideration of the therapeutic quality of the person's environment including: training opportunities, social interactions, functional activities, environmental accommodations, community inclusion, and training and monitoring of those implementing the plan.

5. Consideration of relevant sensory strengths and deficits.

6. Consideration of the person's functional communication skills.

7. Consideration and assessment when needed of the person's preferences, reinforcers and potential reinforcers.

8. Consideration of the person's sleep and eating patterns.

9. Consideration of the person's physical/medical condition, including medical syndromes that may have an impact on problem behaviors.

10. Consideration of the person’s psychiatric condition, if applicable.

11. Consideration of medication effects and side effects.

12. Analysis of objective and measurable data to determine the function that the problem behavior serves for the individual.

13. Identification of appropriate alternative behavior that serves the same purpose (function) as the behavior of concern. This is the replacement behavior.

14. Behavior rating scales/checklists.

15. Historical information from family, previous staff and relevant others.

Documentation: The documents that comprise the functional assessment should be readily available in the behavior support plan.

B. Elements of a Behavior Support Plan

Behavior Support Plans, developed must contain the following elements:

1. Identifying individual information, such as name, age, skills, interests, level of functioning, home address, date of BSP, and signature of the professional who was lead author of the BSP.

2. An operational definition of each problem behavior to be decreased.
   *Can be included in the BSP and/or the person's day or residential plan.

3. An operational definition of each replacement behavior to be increased.
   *Can be included in the BSP and/or the person's day or residential plan.

4. A measurable objective for each problem behavior and replacement behavior with projected completion dates (includes criteria for discontinuation of the objective if it is met within projected date of completion).

5. Procedures for teaching and/or reinforcement of replacement behavior as an alternative for achieving the function of the problem behavior(s).

6. Procedures specific to each problem behavior that specifically addresses prevention, replacement, and management of each problem behavior.

7. The type of data to be collected to assess progress toward the objective(s) for behaviors to be increased and decreased.

8. Provisions, with persons/positions responsible, for training, implementation, review and supervision of the Behavior Support Plan procedures. Training responsibility rests with the BSP author, however approved providers of behavioral supports can train a trainer for a specific BSP (e.g., house manager, service coordinator, etc.) to facilitate the training of all staff who need to implement the behavior support plan. Approval for a local staff member to train others in a specific BSP needs to be documented in writing with the approval for the current plan only. It is expected that anyone providing training on a BSP will be able to provide practical information, answer questions and skillfully demonstrate any procedures included in the plan.

III. USE OF PSYCHOTROPIC MEDICATIONS

Definition: The use of any medication for the primary purpose of affecting overt maladaptive behavior, mood, thought processes, or alleviating symptoms related to a specific diagnosed psychiatric condition.

1) Medications used in this manner will be accompanied by a formal Behavior Support Plan if the person's problem behavior poses a significant risk to him/herself, others, or the environment (i.e., self-injury, physical aggression or property destruction).

2) For people residing in an ICF/MR a BSP is always required (described on the following page). The overall effort that includes the Behavior Support Plan should lead to a less restrictive way of managing and, if possible, eliminating the behaviors and/or psychiatric symptoms for which the medications are employed.

3) A person and his family cannot elect not to have a behavior support plan when a person is prescribed psychotropic medications for overt maladaptive behavior(s) and/or psychiatric symptoms that pose a risk to the person, peers, or the environment and interfere with the person's daily functioning except as noted in IIIc.

Medication is not to be used for disciplinary purposes, for the convenience of staff, as a substitute for a habilitative training program, or in quantities that interfere with a person's quality of life. Each plan should document the fact that any potential risks of the medications employed have been carefully weighed against the risks of the behavior for which the medications are given.

Psychotropic medications should be used only with appropriate consent pursuant to DDSN policy 535-07-PD: Obtaining Consent. PRN orders for psychotropic medications are specifically prohibited. Each DSN Board or QPL provider should have a written policy and assessment format in regard to tardive dyskinesia and apply Policy 603-01-PD, TD Monitoring and 100-29-PD Medication Error/Event Reporting. (e.g., Dyskinesia Identification System: Condensed User Scale/DISCUS). For persons who attend a day program and reside at home, the primary care physician or psychiatrist who prescribed the medication is responsible for TD monitoring. Information on tardive dyskinesia (TD), including TD scores, must be provided to the Human Rights Committee (HRC) and the person giving consent or their guardian/surrogate at the time for review and approval of psychotropic medications.

Psychotropic medications should be reviewed based on the person's needs as determined by the psychiatrist or physician and at least quarterly in a psychotropic drug review process. Persons involved in this Team process should include, but are not be limited to, the physician, person receiving supports and, if the person is not their own legal guardian the legal guardian, an approved provider of behavioral supports, program supervisor, caregiver who knows the person well, nurse (for people in ICFs/MR), and psychiatrist, if applicable. The psychotropic drug review process should provide for gradually diminishing medication dosages and ultimately discontinuing the drug unless clinical evidence justifies that the medication is helping the individual.

When psychotropic medication is used, the team in conjunction with the psychiatrist or attending physician will specify which behaviors/psychiatric symptoms are targeted for change and should, therefore, be monitored both for desired effects and adverse consequences/reactions.

Approval: The Team, HRC, physician, facility administrator or executive director, and the individual and, if the person is not their own legal guardian the legal guardian.

Monitoring: The program director or program supervisor; Team, approved provider of behavioral supports or psychologist, day program supervisor, if applicable, nurse, executive director, pharmacist, if applicable, psychiatrist, or attending physician.

Monitoring in Day Programs: In a day program, the director (as a member of the team) with the approved provider of behavioral supports or psychologist should have responsibility, and in other community residential programs (i.e. CTH and SLP) the responsibility will be that of the program supervisor and approved provider of behavioral supports or psychologist.

A. ICFs/MR Residential Programs

For persons residing in ICFs/MR, a behavior support plan must be in place when psychotropic medications are prescribed for any challenging behavior(s). This is consistent with the South Carolina Code of Laws Section 44-26-10 and federal regulations W-311 and W-312 which include that "drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards reduction of and eventual elimination of the behaviors for which the drug is employed", and "the interdisciplinary team involvement in this decision-making process is inextricably linked to an obligation to develop and implement effective non-drug interventions that address the targeted behavior."

B. Non-ICF/MR Community Residential and Day Programs

A Behavior Support Plan s not required for those receiving Residential, Day Habilitation, or Prevocational Services and psychotropic medication when the person's record documents that:

- The person does not exhibit physical aggression, self-injury, or property destruction or other behaviors that pose a significant risk of harm to themselves, others or the environment. This would be documented by data collected by direct support staff and summarized by the local agency personnel or consultants.

- The team, including a psychiatrist, has determined via the Psychotropic Drug Review Process that the person has reached the lowest effective dosage of the medication based on data collected symptoms/problem behavior of the person.

This documentation needs to be in the persons' record and reviewed/updated annually for as long as the person receives the medication.

C. People Served by DDSN Who Reside at Home

When people reside at home with family and are prescribed psychotropic medications by a private physician (at the referral and request of the family/guardian), DSN service coordination must make efforts to obtain consent from the family to obtain information/documentation about the prescribed medications and reason for their use.

When medications are prescribed to alleviate psychiatric symptoms and/or behavior problems the person should also be offered behavior support consultation for assessment and development of a behavior support plan. For people who reside at home and have a behavior support plan developed, the author of the behavior support plan is responsible for monitoring the program and training the caregivers to record data and implement the plan. If the individual or the family will not grant consent to obtain information about psychotropic medications prescribed, decline offered behavioral supports, and/or report no behavior problems of the individual which interfere with activities of daily functioning and community living, then this information must be documented in the person's single plan and/or file. Such documentation must always be available in the individual's record

and documentation reviewed/updated annually in the person's plan if she or he is prescribed psychotropic medications.

IV. BEHAVIOR SUPPORT PLAN REVIEW AND APPROVAL

Each DSN Board or QPL provider must adopt and implement written policies and procedures governing the assessment, prevention, and management of inappropriate behavior. These policies and procedures must specify all facility or program-approved procedures used for inappropriate behavior. A primary focus is to be on the prevention of problem behavior by using functional assessment data to identify appropriate alternative behaviors to teach and/or reinforce. When consequence-based procedures are to be used, each DSN Board/QPL provider must designate these procedures on a hierarchy, ranging from most positive or least intrusive, to least positive or most intrusive. These procedures must address the following: the use of restraints; the use of medications to manage inappropriate behavior; and the use of aversive consequences.

The DSN Board/QPL provider must designate and use a Human Rights Committee (HRC) to review, approve, and monitor individual plans designed to manage inappropriate behavior and other plans that, in the opinion of the committee, involve risks to individual protection and rights. Individual plans that involve risk, including but not limited to those procedures designated by the DSN Board/QPL provider as being restrictive, require consent pursuant to DDSN policy 535-07-PD: Obtaining Consent.

A. Nonrestrictive Procedures

Definition: Behavior Support Plans that contain only procedures defined as nonrestrictive by DSN Board/QPL Provider policy because the procedures do not limit freedom or cause loss of personal property or rights. Note: Procedures listed in the examples below are often used in everyday generic training by staff and would not require specific team approval unless made part of a BSP.

Examples: Including but not limited to, differential reinforcement, social disapproval, ignoring, simple correction, re-direction, interrupting behavior with educative prompts, and counseling.

Approval: Individual and**,** if the person is not their own legal guardian the legal guardian, and Team including a professional that meets DDSN MR/RD waiver qualifications for behavior support.

Monitoring: Program director or program supervisor, day program director (if individual is in a day program) and an approved provider of behavioral supports.

B. Restrictive Procedures Excluding Restraint

Definition: Behavior Support Plans that contain procedures that limit freedom or cause loss of personal property or rights excluding restraint.

Examples: Residence restriction, 1:1 staffing or increased level of supervision/accountability, response cost, overcorrection, extinction where there is a risk of harm to self or others, satiation involving edibles (requires review by health professionals), and separation procedures lasting more than 5 minutes (excluding the use of timeout rooms).

Approval: Individual and if the person is not their own legal guardian the legal guardian, Team including a professional that meets DDSN MR/RD waiver qualification for behavior support, and HRC.

Monitoring: Program director or program supervisor, day program director if in a day program, an approved provider of behavioral supports, and HRC.

C. Restraint Procedures

Note: Restraint procedures are to be used only for the purpose of protecting an individual or staff from harm and are the least restrictive alternatives possible to meet the needs of the person.

1. Planned Restraint (Manual or Mechanical)

Definition: A procedure that involves holding an individual (i.e., manual restraint) *or applying a device (i.e*., mechanical restraint*) that restricts the free movement of or normal access to a portion or portions of an individual's body.*

Use of the procedure is limited to a maximum of one continuous hour. Release from restraint must occur when the individual is calm and is no longer a danger to self or others. It must be accompanied by an active treatment program (usually a Behavior Support Plan) directed towards reducing the dependency on restraint. A physician's order for restraint is needed but is not required at the time of each use. The order may be included in the routine medical orders which are renewed per state licensure requirements.

Mechanical restraint procedures should be designed and used in a manner that causes no injury and a minimum of discomfort. While in mechanical restraint, the individual will be under continuous observation with documentation of their response to the restraint every 10 minutes not to exceed one hour. This documentation should include the physical condition of the individual (i.e., breathing, circulation).

Note: The use of mechanical devices, such as splints or braces, bed rails to prevent injury, wheelchair harness and lap belts to support an person's proper body positioning are not considered restraint even though they may restrict movement. Such medical necessity for these devices must be documented in the person's record.

Approval: Person and if the person is not their own legal guardian the legal guardian, Team including an approved provider of behavioral supports, HRC, Executive Director.

Monitoring: Program Director or program supervisor, team, a professional that meets DDSN MR/RD waiver qualification for behavior support, day program director if in a day program, and HRC.

2. Use of Mechanical Restraint to Allow Healing of Injury Produced by an Inappropriate Behavior

Definition: Mechanical restraint used for behaviors that do not produce immediate harm but through their chronic/long term nature may result in infrequent harm (e.g., hand mouthing which produces skin breakdown). If a behavior causes an injury requiring the temporary use of restraint to allow healing, the Team must meet and

address the behavior that produced the injury. If the Team develops a Behavior Support Plan to incorporate the restraints, it must include:

a. A schedule for use which specifies checks of the individual's condition every 30 minutes or more frequently depending on the type of device and well-being of the person. The schedule will provide for release 10 minutes at least every hour for motion, exercise, liquids, and bathroom use.

b. A plan for supervision while out of restraint and a plan for teaching appropriate replacement behavior must be included.

c. Restraint should not automatically be reapplied after release unless the problem behavior recurring or a medical condition exists.

d. When the problem behavior is occurring the program should include provisions for application of less intrusive methods prior to application of restraints.

Approval: Individual and if the person is not their own legal guardian the legal guardian, Team including a professional Program Director or program supervisor, team, an approved provider of behavioral supports, HRC, and Executive Director.

Monitoring: Program Director or program supervisor, day program director if individual is in a day program, an approved provider of behavioral supports, and HRC.

D. Psychotropic Medication

Definition: Medications used for the primary purpose of affecting overt behavior, mood, or thought processes, or alleviating symptoms of a psychiatric condition.

Approval: Individual and, if the person is not their own legal guardian the legal guardian, Team including the physician, HRC, Executive Director. Note: The HRC should review information regarding the assessment of tardive dyskinesia for persons receiving psychotropic medication.

Monitoring: Psychotropic drug review process, program director or program supervisor, nurse and/or physician, psychiatrist, and an approved provider of behavioral supports (unless the criteria are met for not having a Behavior Support Plan), and HRC.

E. Aversive Consequences

Definition: A procedure by which staff apply, contingent on inappropriate behavior, startling, unpleasant, or painful consequences, or consequences that have a potentially noxious effect.

Approval: Individual and, if the person is not their own legal guardian the legal guardian, Team including a physician and an approved provider of behavioral supports, HRC, Executive Director, **and the State Director of DDSN or his/her designee.**

Monitoring: Program Director or program supervisor, physician, an approved provider of behavioral supports, HRC, and a designee from DDSN central office.

Note: See also S.C. Code of Laws, Chapter 26, Section 44-26-160:Mechanical, Physical, or Chemical Restraint of Clients; and Section 44-26-170: Use of Certain Types of Behavior Modification.

V. PROHIBITIONS

The following are prohibited:

1. Procedures, devices, or medication used for disciplinary purposes, for the convenience of the staff or as a substitute for necessary supports for the person.

   Note: Restrictive procedures, devices, and/or medication can be used as part of a comprehensive intervention plan that is part of an individual's single plan. Use of restrictive procedures and devices can also be used if the intent is for supports of safety and positioning supports (e.g. bed rails to prevent injury, wheelchair chest harness and lap belts for support positioning). These types of procedures must be monitored closely and documented in the person's single plan and/or file.

2. Seclusion (defined as the placement of an individual alone in a locked room).

3. Enclosed cribs.

4. Programs that result in a nutritionally inadequate diet or the denial of a regularly scheduled meal.

5. Having DDSN consumer discipline other people with disabilities.

6. Prone (i.e. face down on the floor with arms folded under the chest) basket-hold restraint.

7. Timeout rooms

8. Aversive consequences (defined as the application of startling, unpleasant, or painful consequences) unless specifically approved by the State Director of DDSN or his/her designee.

VI. USE OF RESTRAINT AS A HEALTH RELATED PROTECTION

Definition: Restraint (chemical, physical, or mechanical) used during the conduct of a specific medical/dental or surgical procedure, or only if absolutely necessary for a person's protection during the time that a medical condition exists.

The physician/dentist must specify the scheduled use of restraint and its monitoring. If a restraint is applied to prevent a person from removing post-operative sutures, documentation/release requirements would apply since the primary purpose is to manage this behavior. Note: The use of restraint as a health-related protection does not require the development of a Behavior Support Plan.

Note: ICFs/MR should see also DDSN policy 603-03-DD: Managing Maladaptive Behavior During Dental Procedures.

VII. EMERGENCY PROCEDURES

Definition: Procedures used to provide protection from harm in situations where the person is endangering him/herself or others with severely aggressive or destructive behavior. These behaviors could not reasonably have been anticipated in the current setting and there is no approved behavioral, medical or psychiatric program in effect that provides adequate protection from harm.

Authorized emergency procedures are those defined in 567-02-DD, "Preventing and Responding to Aggression" and the PRA manual (e.g. basketholding, two person transport), and procedures outlined in the MANDT, Crisis Prevention Intervention (CPI), or Professional Crisis Management (PCM) curriculum. Emergency situations involving the use of psychotropic medication or mechanical restraint, such as a posey jacket or four-point restraint, shall be authorized in writing by the Executive Director/Facility Director or their designee (or approved by the physician if involving transport to the emergency room) and a report of that emergency provided to the physician or psychiatrist, Executive Director/Facility Director (if approved by a designee), and an approved provider of behavioral supports within 24 hours.

The Executive Director/Facility Director must be notified whenever a designee authorizes emergency restraint. Orders for emergency restraint must not exceed twelve hours during which the person's condition must be documented at least every ten (10) minutes. This 12-hour period is the timeframe in which emergency restraints are authorized, *not the duration of the restraint*. Each use of emergency restraint and justification for its use, including less restrictive methods that have failed, must be noted in the person's record. Emergency mechanical restraints require opportunities for exercise at least ten minutes every hour. This means that the maximum duration of such restraint is fifty (50) consecutive minutes.

The person's legal guardian must be notified immediately of the use of emergency restraint, unless the Team, in conjunction with the legal guardian, has documented other agreed upon timelines for notification or if the person is their own legal guardian and does not want their family notified.

The HRC must be notified of the use of emergency restraint according to a schedule established by the facility or program. PRN orders for mechanical restraints or psychotropic medication are not permitted (unless prescribed by the Emergency room physician). Once a "pattern" of use emerges (i.e., 3 restraints within a 90-day period of time), the Team must meet and develop a plan/strategy for how to prevent escalation or how the Team will respond when behavior does escalate, other than emergency restraint.

VIII. DOCUMENTATION AND TRAINING

Documentation of Results

Pertinent data collection is a prerequisite to any planned intervention. Once a Behavior Support Plan has been implemented, data should be compiled and reviewed at least monthly by a designated program director, supervisor, or service coordinator and an approved provider of behavioral supports. This must include a graph of the person's performance on target behaviors to increase and decrease. Data should be graphed in a manner which notes changes in BSP procedure, psychotropic medications and significant environmental variables (e.g., moving to a new home). Data should be graphed over a sufficient duration to facilitate detection of trends and patterns. This review should be placed in the person's record. The Human Rights Committee will review Behavior Support Plans containing restrictive

procedures (i.e., IV. B, C, D & E) at least annually. The Team must address injuries occurring as a result of procedures contained in a Behavior Support Plan. The Team must send a report of their action within 72 hours to the Executive Director or designee.

Staff Training

Prior to implementing any behavior support plan, staff expected to implement the plan must receive appropriate training. There must be documentation of that training available. Training responsibility rests with the BSP author, however approved providers of behavioral supports can train someone for a specific BSP (e.g., house manager, service coordinator, etc.) to facilitate the training of others who need to implement the behavior support plan. Approval for a local staff member to train others in a specific BSP needs to be documented in writing with the approval for the current plan only. "Blanket approvals" cannot be granted. It is expected that anyone providing training on a BSP will be able to provide practical information, answer questions and skillfully demonstrate any procedures included in the plan.

Positive approaches to behavior support should be included for all new direct support and supervisory employees as part of their pre-service orientation program (but use of the *Carolina Curriculum on Positive Behavior Support/AAIDD Positive Behavior Support Training Curriculum* should be only for staff who have at least 30 – 60 days on the job). Positive approaches to behavior support should be reviewed periodically with employees who have direct contact with persons served by DDSN.

IX. USE OF INFORMAL BEHAVIORAL GUIDELINES AND INTERVENTIONS

There may be times when a formal behavior support plan is not needed to address problem behavior. Informal behavioral guidelines may be appropriate instead if the following conditions are met:

a. The problem behavior does not pose a significant risk to the person, peers, or the environment (excludes behaviors of physical aggression, self-injury, or property destruction).

b. The person is not on psychotropic medication or has reached a minimum effective dose of psychotropic medications.

c. The problem behavior(s) being addressed have a definition that allows for observation and measurement.

d. The guidelines and interventions do not involve any restriction of the person's rights.

The Informal Behavioral Guidelines can be developed by a designated member(s) of the Team and are not billable under the MR/RD Waiver as Behavior Support Services, but would be part of Residential, Habilitation, Day Habilitation and prevocational supports and part of the ICF/MR services. They would be part of the overall plan for the person. The development and implementation of the guidelines needs to include:

a. Collection of baseline and intervention data to assess the effectiveness of the behavioral guideline plan and intervention(s).

b. Training and monitoring of staff to appropriately and consistently implement the informal interventions.

Approval: The Team that includes the individual, and if the person is not their own legal guardian, legal guardian, psychiatrist or physician, and Executive Director.

Monitoring: The Residential Coordinator or Vocational Plan Manager will monitor the data on a monthly basis. This information is to be used during psychotropic drug review meetings if the person receives psychotropic medication. The information will also be used during the planning process to assist the team in evaluating the effectiveness of the Informal Behavioral Guidelines.

Informal behavioral guidelines and interventions will primarily focus on changes in the environmental conditions, changes to the person's activities, changes in staff behavior, and having additional reinforcement available. Two (2) examples of informal behavioral guidelines and interventions are included in Attachment B.

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Attachments: A. Components of Meaningful Environments & Specialized Services

B. Examples of Informal Behavioral Guidelines and Interventions (2)